837 v 4010A1 B2B Testing Instructions

You can view more electronic billing information at our webpage:
www.michigan.gov/mdch >> Providers >> Information for Medicaid Providers >> Electronic Billing.
Any electronic billing questions need to be referred to AutomatedBilling@michigan.gov.

Please be sure to read all of the B2B Instructions, test claim criteria and the electronic submissions manuals before submitting claims. More in depth and detailed instructions are listed within the Electronic Submissions Manual posted at the Electronic Billing webpage. The Electronic Billing webpage also stores many of the important forms and information needed for electronic billing.

Electronic Submission Manual
Section 1 – Authorization to Submit Data Electronically
Section 2 – Introduction to MDCH Electronic Submission
Section 3 – Initial Testing
Section 4 – Preparing Electronic Claim Files
Section 5 – Using the Data Exchange Gateway (DEG)
Section 6 – Files Exchanged
Section 7 – Resources for Electronic Billing

You may being your B2B Testing after you receive your billing agent ID, and you have confirmation that the Billing Agent Authorization Form has been completed. B2B testing is the process of submitting test files to MDCH for processing though the MDCH test environment.

When you are ready to submit test files you will need to create a batch of 837 v 4010A1 claims. For test claims, you must specify a T in the ISA15 segment of the Interchange Envelope. For test Professional Claims, you must specify 004010X098A1 in the GS08 segment.

Information on how to submit files to the Data Exchange Gateway (DEG) is located within the Electronic Submission Manual and the DEG Web User Guide. See the specified chapters above on how to log into our system and the correct codes for submitting and downloading files.

Once you submit an 837 v 4010A1 file, you will then receive back a 997 Acknowledgment. When you receive the 997 you must then send an email, including a contact name, telephone number and email in your organization, to the following contacts to inform MDCH that a test file has been submitted:

Automated Billing: AutomatedBilling@michigan.gov
Felix Carter: CarterF1@michigan.gov *
Daryl Katalenich: KatalenichD@michigan.gov *

*Only email Felix and Daryl on a test file submission. All other emails and questions need to be directed to AutomatedBilling.

To ensure proper retrieval of your files, please use a subject line of "837X Test File DCH00XX" where 837X is the type of file submitted (837P, 837I, 837D) and DCH00XX is your Billing Agent ID.

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The MDCH Automated Billing Unit will review all files that are submitted in the testing environment. You will receive an email explaining if either there were translation errors before we were able to download the file into our system, or summarizing the adjudication of the test file.

The Automated Billing Unit will be available to answer questions that you may have. Please email **all** questions to AutomatedBilling@michigan.gov, not individual team members. The entire testing process takes a minimum of 5-10 business days to complete. Please do not email and request a response if 10business days have not passed.

TEST CLAIM CRITERIA:

The following data is looked at before approving your test files. Please be sure to include examples of all of the appropriate following data. **All test files should include 20 – 100 test claims (Any files with more or less claims will be rejected without analysis).**

Each page represents what will be included in your summary for dental, professional or institutional claims. It also gives the correct Loops and segments where Medicaid expects to receive the information.

INSTITUTIONAL Claim Criteria	
Clean 997 Functional Acknowledgment transaction	• Review Electronic Documents for details
Clean Primary claims submitted	• Review Electronic Documents for details
Clean Secondary/Tertiary claims submitted	• Loop 2300 CAS plus Loop 2320 AMT*C4 should equal Loop 2300 CLM 02 **AND** • Loop 2320 CAS should equal Loop 2300 HI*BE
Prior Authorization Number	• Loop 2300 REF Qualifier G1 & G4
Claim Adjustments/Void Cancel	• Loop 2300 CLM05-3 should be 7 or 8 **AND** • Loop 2300 REF Qualifier F8
Referring Provider ID	• Loop 2310A REF Qualifier 1D
Comments	• Loop 2300 NTE Qualifier ADD
Multiple Modifiers	• Loop 2400 SV202-3 thru SV202-6
Patient Pay Amount	• Loop 2300 HI Qualifier BE
Occurrence Span Codes	• Loop 2300 HI Qualifier BI or BH
Admission Authorization Number	• Loop 2300 REF Qualifier G4
Value Codes	• Loop 2300 HI Qualifier BE

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PROFESSIONAL Claim Criteria	
Clean 997 Functional Acknowledgment Transaction	• Review Electronic Documents for details
Clean Primary claims submitted	• Review Electronic Documents for details
Clean Secondary/Tertiary claims submitted	• Coordination of Benefits (COB) service line balancing requires that the service level charges (Loop 2400 SV102) will equal the COB service level payment (Loop 2430 SVD02) plus the monetary amounts listed in the Claim Adjustment Reason Code (Loop 2430 CAS) segments. • In addition, MDCH expects COB payments at the service level for professional claims.
Prior Authorization Number	• Loop 2300 REF Qualifier G1
Claim Adjustments/Void Cancel	• Loop 2300 CLM05-3 should be 7 or 8 • Loop 2300 REF Qualifier F8
Referring Provider ID	• Loop 2310A REF Qualifier 1D
Comments	• Loop 2300 NTE Qualifier ADD
Multiple Modifiers	• Loop 2400 SV101-3 thru SV101-6
CLIA Number	• Loop 2300 REF Qualifier X4

DENTAL Claim Criteria	
Clean 997 Functional Acknowledgement transaction	• Review Electronic Documents for details
Clean Primary claims submitted	• Review Electronic Documents for details
Clean Secondary and/or Tertiary claims submitted	• Loop 2320A - Other Subscriber Name • Loop 2320 SVR - Other Subscriber Information • Coordination of Benefits (COB) service line balancing requires that the service level charges (Loop 2400 SV102) will equal the COB service level payment (Loop 2430 SVD02) plus the monetary amounts listed in the Claim Adjustment Reason Code (Loop 2430 CAS) segments. • In addition, MDCH expects COB payments at the service level for dental claims.
Prior Authorization Number	• Loop 2300 REF Qualifier G1
Claim Adjustments and Void/Cancel	• Loop 2300 CLM05-3 should be 7 or 8 • Loop 2300 REF Qualifier should be F8
Comments	• Loop 2300 NTE Qualifier ADD
Tooth Number-Letter Surface Code	• Loop 2400 TOO
Modifiers	• Loop 2400 SV301-3 thru SV301-6